VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dlp.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
To Report Adult Abuse: (800) 564-1612
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line:(888) 700-5330

November 15, 2018

Betsy Hutchinson, Manager
Second Spring South
118 Clark Road
Williamstown, VT 05679-9449

Dear Ms. Hutchinson

The Division of Licensing and Protection completed an investigation of a facility self-reported event at your facility on **October 31, 2018**. The purpose of the survey was to determine if your facility was in compliance with Vermont Residential Care Home Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of Correction in the space provided or attach a separate document. A completion date for each plan of correction must be indicated.

Please sign, date, and indicate your title on the bottom of the first page of the report and return this report to this office no later than **November 28, 2018**.

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

You may also request an informal review of all or part of the contents of the notice at any time prior to **November 28, 2018** by calling Suzanne Leavitt, RN, MS, Assistant Division Director, or Clayton Clark, Division Director at (802) 241-0480. If you are not satisfied with the outcome of the informal review with the Division, you may request a review by the Commissioner of Disabilities, Aging and Independent Living. To request a review with the Commissioner, call (802) 241-2401.

The Department is authorized to impose sanctions for failure to correct a deficiency and/or failure to provide proof of correction by the specified Correction Date. Depending on the nature of the violations, the following sanctions may be imposed: administrative penalties of up to $10.00 per resident or $100.00, whichever is greater, for each day the violation remains uncorrected; suspension, revocation or modification of an existing license; refusal to renew a license; suspension of admission or transfer of residents to an alternative placement; injunctive relief to enjoin any act or omission; and the appointment of a receiver for a facility. If you feel strict compliance with the law or regulations would impose a substantial hardship, you may apply to the Department for a variance as stated under Section III of the Residential Care Home Licensing Regulations. You must do so prior to **November 28, 2018**.

Appeals

As noted above, you may seek an informal review from Suzanne Leavitt, RN, MS, Assistant Division Director, or a Commissioner's review of this decision. In addition, you have a right to request a fair hearing with the Human Services Board. Decisions by the Department of Disabilities, Aging and Independent Living can be appealed to the Human Services Board pursuant to 3 V.S.A. §3091. The request for a fair hearing before the Human Services Board must be made within thirty (30) days of your receipt of the notice of this decision, and can be made by writing to the Board at 14-16 Baldwin Street, Montpelier, VT 05633-4302. You have a right to appear before the Board and to present witnesses and other evidence with regard to the case. You also have a right to be represented by an attorney at the Human Services Board fair hearing.

Please contact me at (802) 241-0480 if you have any questions.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0386	A. BUILDING: _____ B. WING _____	C 10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND SPRING SOUTH	118 CLARK ROAD WILLIAMSTOWN, VT 05679

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced, onsite investigation of a facility self reported event from 10/29/2018 through 10/31/2018. The following regulatory violations were identified.	R100		
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the residence failed to ensure that all necessary services were provided in order to meet one applicable resident's psychosocial needs (Resident #1). Findings include: Resident #1, with complex psychiatric and medical needs, was admitted to the residence in 2017. Per Resident #1's nursing care plan, identified goals included management of mental health symptoms, medical diagnoses, and chronic pain. Per nursing care plan, Resident #1 had a history of suicide attempts and self-harming behaviors. Treatment team interventions included in the care plan addressed Resident #1's psychiatric symptoms of anxiety, hallucinations, and pain. Resident #1 experienced a documented period of	R126		

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R126	Continued From page 1	R126		

clinical decompensation on October 2018. Per clinical notes, on 10/22/2018, Resident #1 was quoted as stating, "Please help me", "I don't want to die". Interventions following these statements included notification of the psychiatrist, nursing staff, case management and supervisor. Per psychiatry progress note dated 10/22/2018, Resident #1 was experiencing, "increasing anxiety, bordering paranoia, hallucinations, increased restlessness and agitation". Resident #1 was re-assessed by nursing staff on 10/23/2018 and per documentation s/he, "presented to be disorganized and preoccupied". Resident #1 was then placed on one-to-one staff supervision as a safety measure after confirming to the nurse s/he was experiencing auditory hallucinations. Per nursing notes, Resident #1, "expressed feeling unsafe" but was "unwilling/unready to elaborate" on what was causing these feelings. Nursing documentation dated 10/24/2018 states that Resident #1 became, "tearful and muttered, stating "Just get it over quickly. Just take me quickly". Resident #1 removed money from their pocket and attempted to give it to the Registered Nurse. Additional documentation in Resident #1's record reflected potential changes in mental status. A progress note by direct care staff dated 10/25/2018 as a late entry for 10/24/2018 stated that Resident #1 was on the phone with a family member and said, " I just want you to know you did your best with me" and "I love you very much" I'm sorry, I just struggle, but I'll be ok".

During an interview on 10/30/2018, the Registered Nurse confirmed that Resident #1 appeared disorganized and couldn't directly answer questions related to safety when assessed on 10/24/2018. Per interview, the R.N. confirmed that Resident #1 evaded answering

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R126	Continued From page 2 questions during a nursing assessment, would not confirm or deny experiencing hallucinations and did not contract for safety. The one-to one staff supervision for safety remained in place, and staff-maintained eyes-on supervision of Resident #1 in their room and common areas, with auditory supervision while Resident #1 was in the bathroom. The R.N. confirmed that the information obtained during Resident #1's nursing assessment was shared with treatment team members on the morning on 10/24/2018. The R.N. confirmed lack of knowledge about Resident #1's phone call with family members later in the day on 10/24/2018. During a phone interview on 10/30/2018, the Director of Operations confirmed s/he had initiated a review of clinical documentation and Resident #1 had made, "several concerning statements about safety" on 10/24/2018. While the residence had implemented several interventions including one-to-one supervision, calling the mental health agency crisis screeners, and contacting the psychiatrist for additional medication, there were no additional assessments or clinical interventions in response to Resident #1's clinical presentation that were potential indicators of suicidality or safety risk on 10/24/2018. Resident #1 experienced a medical emergency on 10/25/2018 and died at the residence.	R126		
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition;	R151		

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R151	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the residence failed to ensure that all changes in condition were documented in the resident record for one applicable resident (Resident #1). Findings include: Per record review, a progress note by direct care staff dated 10/25/2018 (as a late entry for 10/24/2018) stated that Resident #1 was on the phone with a family member and stated, " I just want you to know you did your best with me" and "I love you very much. I'm sorry, I just struggle, but I'll be ok". The progress note contained additional information potentially indicative of Resident #1's mental status changes. During an interview with the residence's Registered Nurse on 10/30/2018, the content of Resident #1's documented phone call was unusual and a change from usual communication. Documentation further states that Resident #1 "appeared to be crying" following the phone call. During an interview on the afternoon of 10/30/2018, the Program Manager confirmed that the content of the phone call contained information that was clinically important for the treatment team to be aware of. Documentation reviewed at the residence during the investigation demonstrates that three members of the leadership team are available to staff for after-hours support. The policy, "Emergency Response Procedures- Calling Routine" (approved 4/7/17) states its purpose is, "to provide staff with a clear schematic of whom to call in the event of an emergency or unusual event within the facility". Per interview on 10/30/2018, the Program Manager confirmed that	R151		

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R151	Continued From page 4 information about Resident #1's possible change in condition had not been documented in a timely way, and treatment team members were not aware of the phone call.	R151		